You may enter information on screen and print.

Information for completing pdf forms on-line

Michigan Department of State

Title II of the Americans with Disabilities Act Complaint Form

Please fill out this form completely, in black ink or type. Sign and return to the address on page 2.

Complainant:	
Mailing Address (Street):	
City, State and Zip Code:	
Telephone: Home:	Business:
Person Making the Complaint: (if other than the complainant)	
Mailing Address (Street):	
City, State, and Zip Code:	
Telephone: Home:	Business:
Department/Agency which you believe has discriminated:	
Name:	
Street Address:	
City, State, and Zip Code:	
Telephone Number:	County:
When did the event occur? Date:	
Describe the event providing the name(s) where possible of the individuals who were involved. Continue on the next page, if necessary.	
Has the complaint been filed with the Michigan Department of Civil Rights or the Federal Department of Justice or any other Federal agency or court? Yes ☐ No ☐	
If YES, the complaint has been filed:	
Agency or Court:	Date filed:
Contact Person:	Telephone Number:
Address:	
City, State, and Zip Code:	

Please continue on next page

Do you INTEND to file with another agency or court? Yes ☐ No ☐
If YES, you INTEND to file:
Agency or Court:
Address:
City, State and Zip Code:
Telephone Number:
Additional space for answers:
Signature:
Date:

Send completed form to:

Bari E. Thomas
ADA Coordinator
Office of Human Resources
Michigan Department of State
P.O. Box 30775
Lansing, Michigan 48909-8275

Print Clear Form